

TRAUMATIC BRAIN INJURY (TBI) WAIVER PROGRAM PARTICIPANT REQUEST TO TRANSFER

PARTICIPANT INFORMATION:

Last _____ First _____ Middle Initial _____

Street Address _____

City _____ State _____ Zip Code _____ County _____

Date of Birth ____/____/____ Medicaid Number: _____

Phone Number: () _____ - _____

Legal Representative _____

Phone Number: () _____ - _____ (If applicable) () _____ - _____
Home Cell

Personal Attendant Service Preferences:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours per day:							

<input type="checkbox"/> TRADITIONAL AGENCY TRANSFER
I wish to transfer from my current provider: <input type="checkbox"/> Case Management Agency-(Name) _____ <input type="checkbox"/> Personal Attendant Service Agency-(Name) _____
<input type="checkbox"/> PERSONAL OPTIONS TRANSFER
<input type="checkbox"/> I wish to transfer from Personal Options to a Traditional Agency Model. <input type="checkbox"/> I wish to transfer from the Traditional Agency Model to Personal Options.

I want to transfer because _____

I understand that I will be contacted by KEPRO to explain the transfer process and my freedom of choice options.

 Participant/Legal Representative Signature _____
 Date

Fax Form To:
 KEPRO
 1.866.607.9903